

Complete Summary

GUIDELINE TITLE

Treatment of adolescents with substance use disorders.

BIBLIOGRAPHIC SOURCE(S)

Substance Abuse and Mental Health Services Administration (SAMHSA).
Treatment of adolescents with substance use disorders. Rockville (MD): U.S.
Department of Health and Human Services, Public Health Service, Substance
Abuse and Mental Health Services Administration, Center for Substance Abuse
Treatment; 1999. (Treatment improvement protocol (TIP) series; no. 32). [177
references]

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CATEGORIES

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SCOPE

DISEASE/CONDITION(S)

Substance use disorders

GUIDELINE CATEGORY

Treatment

CLINICAL SPECIALTY

Family Practice

Pediatrics

Psychiatry

Psychology

INTENDED USERS

Advanced Practice Nurses
Nurses
Other
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

- To present information on substance use disorder treatment for adolescent clients
- To help treatment providers design and deliver better services to adolescent clients with substance use disorders
- To help governmental agencies and treatment providers establish, fund, operate, monitor, and evaluate treatment programs for substance-using adolescents

TARGET POPULATION

Adolescents with substance use disorders, including youth in juvenile justice system; homeless youth; homosexual, bisexual, and transgendered youth; and, youths with coexisting disorders

INTERVENTIONS AND PRACTICES CONSIDERED

1. Treatment plan
2. 12-step-based programs
3. Therapeutic communities
4. Family therapy
5. Individualized treatment for youth in juvenile justice system; homeless youth; homosexual, bisexual, and transgendered youth; and, youths with coexisting disorders
6. Inpatient, outpatient, and continuing care
7. Treatment decisions using the problem severity continuum

MAJOR OUTCOMES CONSIDERED

- Efficacy of treatment, as reflected by:
 - Frequency and extent of substance use
 - Crime rates
- Adolescent mortality related to substance use disorders
- Adolescent morbidity related to substance use disorder
 - Prevalence of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) infection
 - Rate of unwanted pregnancies
 - Prevalence of conduct disorders
 - Incidence of developmental problems
 - Prevalence of injuries caused by substance use

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic for a Treatment Improvement Protocol (TIP), the Center for Substance Abuse Treatment creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected.

Recommendations from this Federal panel are then transmitted to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols and arrives at agreement on protocols. A Chair for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of field experts closely reviewed the draft document

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The following summary was excerpted from the main text by the guideline developer. To avoid sexism and awkward sentence construction, the Treatment Improvement Protocol (TIP) alternated between "he" and "she" in generic examples.

Substance Use Disorder Treatment and Adolescents

In 1997, substance use among 12- to 17-year-old children rose to 11.4 percent with illicit drug use among 12- and 13-year-olds increasing from 2.2 to 3.8 percent, according to the 1997 National Household Survey on Drug Abuse conducted by the Substance Abuse and Mental Health Services Administration. Moreover, perceived risk of harm from substance use is falling while the availability of drugs is climbing. These trends indicate a major national problem, especially as the social and economic costs of adolescent substance use are becoming better understood. The onset of substance use is occurring at younger ages, resulting in more adolescents entering treatment for substance use disorders with greater developmental deficits and perhaps much greater neurological deficits than have been observed in the past. Other consequences of substance use and abuse include alcohol- and drug-related traffic accidents, delinquency, sexually risky behavior, and psychiatric disorders.

Adolescent users differ from adults in many ways. Their drug and alcohol use often stems from different causes, and they have even more trouble projecting the consequences of their use into the future. In treatment, adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations (e.g., strong peer influences). At a physical level, adolescents tend to have smaller body sizes and lower tolerances, putting them at greater risk for alcohol-related problems even at lower levels of consumption. The use of substances may

also compromise an adolescent's mental and emotional development from youth to adulthood because substance use interferes with how people approach and experience interactions.

The treatment process must address the nuances of each adolescent's experience, including cognitive, emotional, physical, social, and moral development. An understanding of these changes will help treatment providers grasp why an adolescent uses substances and how substance use may become an integral part of an adolescent's identity.

Regardless of which specific model is used in treating young people, there are several points to remember when providing substance use disorder treatment:

- In addition to age, treatment for adolescents must take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.
- Some delay in normal cognitive and social-emotional development is often associated with substance use during adolescence. Treatment for adolescents should identify such delays and their connections to academic performance, self-esteem, or social interactions.
- Programs should make every effort to involve the adolescent client's family because of its possible role in the origins of the problem and its ability to change the youth's environment.
- Although it may be necessary in certain geographic areas where availability of adolescent treatment programs is limited, using adult programs for treating youth is ill-advised. If this must occur, it should be done only with great caution and with alertness to inherent complications that may threaten effective treatment for these young people.
- Many adolescents have explicitly or implicitly been coerced into attending treatment. Coercive pressure to seek treatment is not generally conducive to the behavior change process. Treatment providers should be sensitive to motivational barriers to change at the outset of intervention. Several strategies can be used for engaging reluctant clients to consider behavioral change.

Tailoring Treatment to the Adolescent

Adolescent substance use occurs with varying degrees of severity. The degree of substance involvement is an important determinant of treatment, as are any coexisting disorders, the family and peer environment, and the individual's stage of mental and emotional development. This information should be used to refer the client to appropriate treatment.

It is useful to consider a substance use continuum with these six anchor points:

- Abstinence
- Use: Minimal or experimental use with minimal consequences
- Abuse: Regular use or abuse with several and more severe consequences
- Abuse/Dependence: Regular use over an extended period with continued severe consequences
- Recovery: Return to abstinence, with a relapse phase in which some adolescents cycle through the stages again

- Secondary abstinence

Treatment interventions fall along a continuum that ranges from minimal outpatient contacts to long-term residential treatment. All levels of care should be considered in making an appropriate referral. Any response to an adolescent who is using substances should be consistent with the severity of involvement. While no explicit guidelines exist, the most intensive treatment services should be devoted to youth who show signs of dependency--that is, a history of regular and chronic use--with the presence of multiple personal and social consequences and evidence of an inability to control or stop using substances.

Assessment

The guidelines below show how the continuum can be used in making a decision regarding the placement of the adolescent. The Revision Panel created the guidelines based on clinical experience.

- In making placement decisions, practitioners should choose the most intensive level of care indicated by any single assessment criterion.
- When an assessment indicates the need for a particular level of care that is not available, it is desirable to refer the adolescent to the next higher level of care, unless the assessment indicates that such a placement would be counterproductive. Naturally, a higher level of care may not be practical or available.
- Assessment is an ongoing process. Decisions about level of care should be based on the adolescent's progress and changes in his environment. Clients should have the opportunity to move back and forth across the level of care continuum based on changes in these factors.
- Assessors should have an indepth knowledge of available services and their quality and intensity.
- Adolescents may move into or through different treatment programs based on their progress and/or changes in the environment. Prior to each program change, indepth reassessment must be completed and the results communicated between providers.

General Program Characteristics

Program design, a policies and procedures manual, ongoing evaluation, and a planned approach to legal concerns make up the framework for a treatment program. Within this framework, issues to consider include staff recruitment and training, treatment components, treatment planning, and client services.

Staffing

Staff members should represent the cultural diversity of the program's client population. In addition, the facility's forms, books, videos, and other materials should reflect the culture and language of the clientele. Innovative and intensive continuing education, staff development, and outreach efforts during staff recruitment may be needed to improve cultural competence among staff. If a significant part of the client population is non-English-speaking, at least one staff member should be bilingual and bicultural. Someone on staff should be familiar

with disability issues and disability culture: For example, people who are deaf who use American Sign Language have their own culture.

Most important is to schedule staff training periodically throughout the year. This is greatly preferable to training presented in ad hoc situations to address crises or acute situations.

Ongoing training should address a range of specialty topics, including the following:

- Treatment approaches specific to adolescents and their families
- Family dynamics and family therapy
- Adolescent growth and development
- Sexual and physical abuse
- Gender issues
- Mental health problems
- Different cultural and ethnic values
- Psychopharmacology
- Referral and community resources
- Cognitive impairments
- Legal matters

When recovering individuals are hired, they should have the same level of expertise and training required of other staff members in the same position. Recovering individuals must have clear evidence of abstinence from alcohol and drugs for 2 to 5 years.

Program Components

The core components of many adolescent treatment programs, regardless of their therapeutic orientation, include the following:

- Orientation, the first step in treatment, clarifies to the adolescent what treatment is, her role in treatment, and the concept of program expectations. Orientation should be conducted in a nonconfrontational style and tone in order not to raise the adolescent's anxiety, which may already be heightened by other aspects of the treatment program.
- Daily scheduled activities of school, chores, homework, and positive recreational activities can help adolescents learn new skills and provide them with an alternative to their substance-using behavior and can help ensure that adolescents remain sober after treatment.
- Peer monitoring in a group setting can help the client build the strength necessary to override peer pressure and harness the influence of the peer group in a positive manner.
- Conflict resolution is often necessary given that there is a high potential for conflict between young clients and program staff. Such conflicts can arise from a staff member's inexperience in working with adolescents or a client's inability or unwillingness to meet program expectations, in which case the treatment plan should be modified. In any event, staff should take a proactive stance in resolving conflicts.
- Client contracts (e.g., behavioral contracts, including substance-free contracts) are negotiated and signed by both the adolescent and primary

counselor; they lay out concrete treatment goals, expectations, time frames, and consequences (if the contract is not followed) that are mutually acceptable to the client and counselor. They can help identify the current level of the adolescent's functioning and developmental markers, providing a baseline from which to monitor change. They also give to adolescents a sense of control in going through treatment and a degree of investment in their well-being.

- Schooling, which generally focuses on substance use and basic education, is one of the most important factors in an adolescent's recovery. Whether the schooling is provided on or off site, it should be fully integrated into an adolescent's program. Teaching staff should be considered part of the treatment team. For adolescents who attend public schools, a liaison between the school and treatment program should be designated.
- Vocational training is an important intervention and should be part of an adolescent's treatment. Appropriate interventions include prevocational training, career planning, and job-finding skills training. Without these skills, many youths may be more likely to support themselves through illegal activities and thus be more prone to relapse.

The level of intensity of these components will vary considerably from outpatient to residential treatment.

Treatment Planning

At a minimum, a treatment plan should identify the following:

- Problems of the client and the family, including substance use, psychosocial, medical, sexual, reproductive, and possible psychiatric disorders
- Goals that are attainable and help clients to recognize their involvement with substances and to acknowledge responsibility for the problems resulting from substance use
- Strengths and resources of the individual and the family and ways to apply them to address treatment goals
- Objectives that are realistic and measurable steps for achieving each goal
- Interventions such as treatment strategies and services that are needed to achieve the objectives
- Educational, legal, and external support systems

The treatment plan should include pre-established times for evaluation and adjustment of goals as necessary. Treatment programs also should work closely with other entities that are involved in the treatment of adolescents, such as school systems, child welfare, and juvenile justice agencies. Interagency agreements, also known as memoranda of understanding, should be developed that describe payment policies, funding problems, mutual goals for clients, and intra- and interagency contracts. In addition, it is important to have an established practice of exchanging signed releases of information from each shared client, insofar as the client agrees to the sharing of information, so that the involved staff members can more freely exchange confidential information about the client's progress.

12-Step-Based Programs

In programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), sobriety is maintained by carefully employing a 12-Step philosophy and by sharing experiences with others who have suffered similar problems with substance abuse and dependency. Many clients who are involved with AA/NA find another member who will serve as a sponsor and provide guidance and help in times of crisis when the urge to return to drinking or drug use becomes overwhelming.

Providers treating adolescents in a 12-Step-based program should bear the following in mind:

- Substance use disorders are primary, multifaceted illnesses that exist in people of all ages, including adolescents.
- Persons with substance use disorders are individuals who share a common problem but have unique and separate needs and therefore should be treated with respect and dignity.
- Once substance-using adolescents are informed about addiction in an understandable way, they are capable of helping others, as long as they receive some guidance.
- Use of group therapy is well suited to adolescents, who tend to rely heavily on peer examples and approval.
- The principles of recovery outlined by AA/NA provide effective and proactive tools for continuing recovery from substance involvement.
- Once a person has lost control over his use of substances as an adolescent, returning to responsible and legal use as an adult may require additional help and support.

Most 12-Step-based programs focus on the first five steps during primary treatment, while the remaining ones are attended to during aftercare. Below are ways to present the first five steps to adolescents so that their specialized developmental needs can be addressed.

- Step 1: We admitted we were powerless over alcohol--that our lives had become unmanageable. With adolescents, the primary goal of this step is to assist them in reviewing their substance use history and to have them associate it with harmful consequences.
- Step 2: We came to believe that a Power greater than ourselves could restore us to sanity. To convey this message, allow new clients to interact with those who have been successful in treatment and are leaving the program. Providers must help adolescents with coexisting mental illnesses or cognitive disabilities to understand that Step 2 refers to obtaining help to stop drug seeking and use behavior.
- Step 3: We made a decision to turn our will and our lives over to the care of God as we understood Him. This step can be simplified by saying, "Try making decisions in a different way; take others' suggestions; permit others to help you." Using the phrase "Helping Power" instead of "Higher Power" can benefit some.
- Step 4: We made a searching and fearless moral inventory of ourselves; Step 5: We admitted to God, to ourselves, and to another human being the exact nature of our wrongs. Steps 4 and 5 provide an opportunity to be accepted by another person in spite of one's past behaviors and to take a "personal inventory" of those past behaviors.

Therapeutic Communities

As a social-psychological form of treatment for addictions and related problems, the TC has been typically used in the United States to treat youth with the severest problems and for whom long-term care is indicated. TCs have two unique characteristics:

1. The use of the community itself as therapist and teacher in the treatment process
2. A highly structured, well-defined, and continuous process of self-reliant program operation

The community includes the social environment, peers, and staff role models. Treatment is guided by the substance use disorder, the person, recovery, and right living.

Traditionally in the therapeutic community, job functions, chores, and other facility management responsibilities that help maintain the daily operations of the TC have been used as a vehicle for teaching self-development. The day is highly structured, with time designated for chores and other responsibilities, group activities, seminars, meals, and formal and informal interaction with peers and staff. The use of the community as therapist and teacher results in multiple interventions that occur in all these activities.

For the adolescent, the community may be even more crucial than for adults since the TC functions as family. This is an exceedingly significant function, since many youth in TCs come from dysfunctional families.

Modifications that are generally made in the TC model for treatment of adolescents can be summarized as follows:

- The duration of stay is shorter than for adults.
- Treatment stages reflect progress along behavioral, emotional, and developmental dimensions.
- Adolescent programs are generally less confrontational than adult programs.
- Adolescents have less say in the management of the program.
- Staff members provide more supervision and evaluation than they do in adult programs.
- Neurological impairments, particularly learning disabilities and related disorders, such as attention deficit/hyperactivity disorder (AD/HD), must be assessed.
- There is less emphasis on work and more emphasis on education, including actual schoolwork, in the adolescent program.
- Family involvement is enhanced in adolescent programs and ideally should be staged, beginning with orientation and education, then moving to support groups, therapy groups, and therapy with the adolescent. When parental support is nonexistent, probation officers, social workers, or other supportive adults in the youth's life can participate in therapy.

Clinical wisdom suggests that the ideal duration of treatment for adolescents in a TC is 12 to 18 months and that adolescents with very deep and complicated disorders cannot be treated effectively in 28 days.

Staffing in TCs continues to include non-degreed, recovering individuals as adjunctive staff, as well as professionally trained, degreed specialists. Having a nurse on site is ideal, in part to provide cross-training for the counselors, particularly regarding the symptomatology of addiction. The nurse should be well-versed in sexuality, reproductive health, and sexually transmitted diseases (STDs), including diagnosis, treatment, and issues surrounding partner notification. Teachers in a TC program for adolescents must have an understanding of substance use disorders among youth.

TC residents move through stages of increasing responsibility and privileges. To advance to the next level, the adolescent must demonstrate responsibility, self-awareness, and consideration for others. In adult TCs, the final stage is taking some responsibility for operating the TC; this is not appropriate for adolescents, for whom the staff plays the role of effective parents.

Ideally, TCs should provide their own schools with licensed teachers as well as satellite aftercare programs in the communities where the residents live. For adolescents, aftercare programs should include a family therapy component. Programs should develop cooperative working agreements with their local juvenile probation departments to coordinate the referral, screening, and follow-up and to ensure this population's access to appropriate treatment. Prevocational and vocational training should be incorporated whenever possible.

A TC environment should help clients come to terms with sexual issues (e.g., sexual identity, previous sexual abuse) through one-on-one counseling, encounter groups, sex education classes, and other special sessions. Dating and sexual contact between clients should be prohibited. Boys' and girls' living spaces should be separated. The longer term stay and increased contact make TCs a good environment for counseling and education on other issues such as smoking and STDs.

Family Therapy

Substance use disorder treatment programs can employ family therapists to apply therapeutic approaches that have proven effective with adolescents and their families. A therapist who practices a family-based approach should have formal, professional training in this method. Family therapy fits well into the regimen of treatment where case management is used; it also has been proven effective in home-based treatment.

Contemporary family therapy approaches understand the importance of treating individuals as subsystems within the family system and as units of assessment and intervention; in other words, each member of the family is capable of being assessed and can act as a unit of intervention, for example, by changing his interactional patterns. Family-based treatments work with multiple units, including individual parents, adolescents, parent-adolescent combinations, and whole families, as well as family members vis-a-vis other systems. Contemporary family approaches also target extended systems, most notably an adolescent's peers, school, and neighborhood, which are believed to contribute to dysfunctional interactions in families.

The therapist's intervention aims to change the way family members relate to each other by examining the underlying causes of current interactions and encouraging new (and presumably, healthier) ones. The therapist should help family members appreciate how the values and perspectives of each family member may differ from their own, but that differences do not have to be a source of conflict. Helping the family members solve problems together in the therapeutic setting enables them to learn strategies that can be applied with the adolescent in the home. Such maneuvers in therapy decrease family conflicts and improve the effectiveness of communication.

Family treatment also equips parents with the skills and resources necessary to address the inevitable difficulties that arise in raising teenagers. The family therapist's job is to help parents regain their optimism and motivate them to continue to help their teenager. Family therapists should bolster the parents' self-confidence as parents while at the same time helping them improve their parenting skills. Parents are taught how to provide age-appropriate monitoring of their teenager (e.g., to know their friends, to know how they spend their time), set limits (e.g., negotiate with the youth about reasonable curfews, schedules, and family obligations), establish a system of positive and negative consequences, rebuild emotional attachments, and take part in activities with the adolescent outside the home.

Family therapy can include discussion of the effects of the teenager's actions in extrafamilial systems--such as skipping an appointment with a probation officer or hanging out with peers late at night on unsafe street corners where drugs are bought and sold. Then the therapist might meet with the probation officer or ask the adolescent to bring a peer to a session to review the problem from the youth's perspective.

Family therapists should be acutely aware of the complex of behaviors and systemic interactions associated with recovering from a substance use disorder. They also must be aware of cultural differences in family patterns and typical attitudes toward therapy. Adolescent substance involvement should be considered within the context of other problem behaviors such as delinquency and school problems, necessitating new frameworks of diagnosis and assessment, as well as treatment.

Adolescent clients will benefit when the treatment team, including substance abuse counselors, nurses, and doctors, working in conjunction with family therapists, have a general understanding of family therapy within the substance use disorder treatment setting. When they have this understanding, the treatment team members can best support the efforts of the therapist and coordinate their components of treatment with family therapy.

Most important in family therapy is the therapeutic alliance between the therapist and adolescent. It is crucial for the therapist to emphasize to the client and family members that the purpose of the therapy is to help the client.

Youths with Distinctive Treatment Needs

Young people who have distinct concerns related to coexisting psychiatric conditions, sexual orientation, involvement with the criminal justice system,

physical health, or displaced living conditions may not do well in traditional treatment programs. Therefore, treatment providers should offer individualized treatment, paying particular attention to the events and circumstances that contributed to the client's current situation. Problems that often accompany substance use disorders include illegal activity, homelessness, shame surrounding sexual orientation, and coexisting physical and mental disorders.

Youth in the Juvenile Justice System

Every young person involved in the juvenile justice system should undergo thorough screening and assessment for substance use disorders, physical health problems, psychiatric disorders, history of physical or sexual abuse, learning disabilities, and other coexisting conditions. Juvenile probation officers can be helpful partners in the system of care. For their part, providers should educate the local juvenile justice system about the importance of early intervention and the resources available to it. It is almost impossible to intervene here unless the youth is removed from the environment that brought him into conflict with the juvenile justice system in the first place (e.g., the home neighborhood). Early intervention is critical in working with adolescents who have come into contact with the juvenile justice system.

Homeless Youth

Research shows that homeless youths are at high risk for a wide range of problems, including substance use disorders. Effective treatment for this population hinges on recognizing these young people's readiness for treatment. For adolescents who are living on the streets, outreach becomes a primary intervention strategy. Outreach programs should have in place a "step-up" for homeless or inner-city youths to enter these programs, assisting them in negotiating the various obstacles that may be potential barriers to services. Street outreach workers should focus on developing trusting relationships with youths that, over time, can influence a young person to access treatment services for substance use disorders. Service providers must meet with, talk to, and develop relationships with young people on the street to engage them in treatment. Returning homeless or runaway youth to their homes is not always in their best interest because less than optimal conditions may exist in these homes. Treatment providers should explore the appropriateness of other transitional living options for homeless youth if necessary.

Once a homeless youth has entered the system, the next step is establishing a case management plan that is based on a thorough assessment of her needs. Possible services should include finding housing, dealing with family problems, entering substance use disorder and/or HIV-related treatment, and providing schooling, sexual and reproductive health care, and job training. It may be necessary to prioritize the needs for services according to the individual's problems.

Homosexual, Bisexual, and Transgendered Youth

Adolescence is a very lonely, high-risk time for many youths who have sexual identity issues. Many gay, bisexual, and transgendered youths have no one in whom they can confide, and most communities lack gay-identified services. Gay-

specific services are likely to be more sensitive to the importance of not divorcing the issues of sexual identity from substance use problems during the treatment process. Effective treatment for these youths involves helping them to feel comfortable with, and to take pride in, their sexual identity.

Coexisting Disorders

Any adolescent who is being treated for substance use disorders and is also taking psychoactive medications for a coexisting psychiatric disorder requires careful psychopharmacological management. These adolescents should also be given routine urine testing as part of their treatment plan. Close scrutiny of adolescents with AD/HD is particularly important for those who are receiving substance use disorder treatment. Treatment providers and mental health authorities should develop programs together to treat youth with coexisting disorders. Cross-training can help staff of both programs develop the sensitivity and the clinical skills to understand coexisting disorders and to identify the presence of either problem or both. Youths who have coexisting disorders and are not on psychoactive medications do better in programs that provide both substance use disorder and mental health treatment together than in separate programs. For more information on coexisting psychiatric conditions and substance use disorders, refer to TIP 9, Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse.

Legal and Ethical Issues

Because of the complexity of the consent issue, programs in States with laws that do not clearly allow admission of adolescents without parental consent or notification should develop a special admissions policy. This policy should be based on these variables:

- State law regarding treatment of adolescents (i.e., whether parental consent and/or notification is required)
- State law regarding program liability if adolescent clients in need are turned away
- The family circumstances as related by the adolescent (the adolescent's view of his family may be verified, with his consent, by contacting an adult who knows the family well)
- The adolescent's age and emotional, cognitive, and social maturity
- The kind of treatment the program provides
- The program's financial capacity to provide treatment without reimbursement from family
- Potential for exposure to a lawsuit should the program admit the adolescent

With the above factors in mind, the program should assess its potential liability if the adolescent is admitted without parental consent in a State where such consent is required.

Programs Governed by Federal Confidentiality Regulations

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for adolescents with substance use disorders must comply with the Federal confidentiality regulations

(42 C.F.R. _2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid such as tax-exempt status or State or local government funding coming (in whole or in part) from the Federal government.

Coverage under the Federal regulations does not depend on how a program labels its services. Calling itself a "prevention program" does not excuse a program from adhering to the confidentiality rules. It is the kind of services, not the label, that will determine whether the program must comply with the Federal law.

Information that is protected by the Federal confidentiality regulations may be disclosed only after the adolescent has signed a proper consent form. In some States, parental consent must also be obtained. The adolescent may revoke consent at any time, and the consent form must include a statement to this effect. The form must also contain a date, event, or condition on which it will expire if not previously revoked. Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with patient consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient cannot further disclose or release such information unless permitted by the regulations. Programs assessing or treating adolescents who are involved in the criminal justice system or juvenile justice system (juvenile court) must also follow the Federal confidentiality rules.

Duty to Warn

If an adolescent's counselor thinks the teenager poses a serious risk of violence to someone, there are at least two questions that must be answered:

1. Does a State statute or court decision impose a duty to warn in this particular situation?
2. Even if there is no State legal requirement that the program warn an intended victim or the police, does the counselor feel a moral obligation to warn someone?

The first question can only be answered by an attorney familiar with the law in the State in which the program operates. If the answer to the first question is "no," it is advisable to discuss the second question with a knowledgeable lawyer, too. A similar dilemma also arises when providers know that an adolescent they are treating is infected with HIV or if the adolescent has committed a criminal act.

Reporting Child Abuse and Neglect

All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made. Because of the variation in State law, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance.

When a program makes such a report, it should notify the family, unless the notification would place the child in further danger. The program should also endeavor to continue to work with the family as the State investigates the complaint and the child protective process unfolds. Families should never be abandoned because of suspected abuse or neglect, and health care providers should be wary of making judgments until a comprehensive assessment has been completed by State authorities.

CLINICAL ALGORITHM(S)

An algorithm is provided for a Decision Tree: Should a program admit an adolescent to treatment without parental consent/notification?

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall, treating an adolescent with substance use disorders as early as possible maximizes the opportunity to stem the initially short-term, but potentially long-term, ill effects.

Administering treatment to adolescents could greatly prevent future substance use related-problems as the adolescent transitions into adulthood.

Specific benefits of treatment include:

- Abstinence from substance use:
 - 40-60% of those treated with a 12-step-based program (data from one large study, not controlled and several smaller studies, none controlled)
 - 53% of those treated with a 12-step-based approach reported either abstinence or minor relapses 12 months post-treatment versus 15% and 27% for those who did not complete treatment or received no treatment, respectively (data from a medium sized study, better methodology, not controlled)
- Reduction in substance use frequency and extent: 23% of those treated with a 12-step-based program used substances less (data from one large study)
- Reduction in level of criminal activity (violent crimes, drug sales, property crimes)

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The opinions expressed in the guideline document are the views of the Consensus Panel members and do not reflect the official position of CSAT, SAMHSA, or the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT, SAMHSA, or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized client care and treatment decisions.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Treatment Improvement Protocols (TIPs) are distributed to facilities and individuals across the country.

The TIP describes effective models of treatment of substance use disorders in adolescents. Appendix B in the guideline document provides information of the medical management of drug intoxication and withdrawal. Legal and ethical issues are presented in the TIP, and an example of a consent form is included.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Substance Abuse and Mental Health Services Administration (SAMHSA). Treatment of adolescents with substance use disorders. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1999. (Treatment improvement protocol (TIP) series; no. 32). [177 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1993 (updated 1999)

GUIDELINE DEVELOPER(S)

Substance Abuse and Mental Health Services Administration (U.S.) - Federal Government Agency [U.S.]

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GUIDELINE COMMITTEE

Treatment Improvement Protocol Series 32 Consensus Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This document is a revision and update of Treatment Improvement Protocol (TIP) 4, which was published in 1993 by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

In 1992, CSAT convened a Consensus Panel, and the result of that Panel's work was TIP 4, Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents. In July 1997, CSAT convened a small Revision Panel to review TIP 4. The Panel recommended changes and developed content for this revised TIP.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [National Library of Medicine \(NLM\) Health Services Technology Assessment Text \(HSTAT\) database](#).

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from [NCADI's Web site](#) or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

None available

NGC STATUS

This summary was completed by ECRI on April 25, 1999. It was verified by the guideline developer on July 26, 1999.

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